

E R R A T A

January 6, 1987

TO: All County Welfare Directors

SUBJECT: Reduction of Federal Funding for Refugee Demonstration Project
Participants from 36 to 31 Months

REFERENCE: All-County Letter 86-113

In our November 12, 1986 All-County Letter (ACL) regarding Reduction of Federal Funding for Refugee Demonstration Project Participants from 36 to 31 months, under I. Program instructions, Item A, Notice of Actions (NOAs) were enclosed to reflect the reduction from 36 to 31 months. The back of the NOA titled NA 290 (8/82) Cash Aid/MC - General Notice, was incorrect. The back should have an NA Back 5 (Cash Aid/FS) instead of the NA Back 3 (Cash Aid/FS). A corrected camera-ready copy of this notice is enclosed for your use.

If you have any questions concerning this letter, please contact
Ms. Roberta Wilson, Office of Refugee Services, at (916) 445-0563 or
ATSS 485-0563.

Enclosure

cc: CWDA
Dr. Sharon Fujii

Notice of Action

*If you have questions or want more information
about this action, please contact your worker.*

Case Name :
Case Number :
Worker :
Phone :
Date :

Description of the Action, Amount, Reason(s), Comments. Effective _____, the following action is being taken:

Because you've lived in the United States for more than thirty-one months, the Refugee Demonstration Project must stop your cash aid. You will get a separate notice for Medi-Cal.

You and your family may still get cash aid under other programs. Phone your worker at _____.

Neither you or your family can get AFDC because: _____

Regulations. This action is required by State regulations which are available for review at the county welfare department: Manual of Policies and Procedures (MPP) Section(s) 69-213.3.

Medi-Cal — California Administrative Code Title 22, Section(s) 50179, 50179.5, 50183, 50227

State Hearing. If you are dissatisfied with this action, your aid may continue unchanged if you ask for a State Hearing before the effective date of the action. Read the back for important information about your right to appeal this action.

Your Right to Appeal This Action

If you are dissatisfied with the action described on the other side, or any other county action, you may request a state hearing before a Hearing Officer of the State Department of Social Services. This hearing will be conducted in an informal manner to assure that everyone present is able to speak freely. Your county or adoption worker can help you request a hearing. If you decide to request a hearing you must do so **WITHIN 90 DAYS OF THE MAILING DATE OF THIS NOTICE.**

FOOD STAMPS AND CASH AID†: If this action stops or reduces your food stamps or cash aid and you ask for a hearing before the effective date of the action, your benefits may continue unchanged under certain circumstances until the hearing or until you receive your hearing decision. Food Stamps will not continue past the end of your current certification period.

Authorized Representative

You can represent yourself at the state hearing. You can also be represented by a friend, attorney or any other person, but you are expected to arrange for the representative yourself. You can get help in locating free legal assistance by calling the toll-free number of Public Inquiry and Response.

How to Request a State Hearing

The best way to request a hearing is to fill in and send this entire notice to:

You may also request a hearing by calling the toll-free number of Public Inquiry and Response.

Public Inquiry and Response (Public Information)

Toll-Free Number: (800) 952-5253*

For the Deaf Only TDD (800) 952-8349*

*You may have to dial "1" first.

The State Public Inquiry and Response Unit can provide you with further information about your hearing rights or files or other welfare-related matters. Assistance is also available in some languages other than English, including Spanish. You may phone, write or come in.

Public Inquiry and Response
State Department of Social Services
744 P Street, Mail Station 16-23
Sacramento, CA 95814

Request for a State Hearing

Name	Phone number		
()			
Address	City	State	Zip Code

I am requesting a state hearing because of an action by the welfare department of _____ county related to my family's: ☐ Cash Aid ☐ Food Stamps ☐ Medi-Cal ☐ Adoption Assistance Program Payments

Reasons for my request:

☐ I speak a language other than English and need an interpreter for my hearing. (The state will provide the interpreter at no cost to you.)

Language	Dialect
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†If you request a state hearing and your benefits continue unchanged, the county can recover as an overpayment the cash aid and value of food stamps the hearing decision finds you were not eligible for. If you remain eligible to receive cash aid after the hearing, and you have no other income or resources, your grant will be reduced by 10% each month until the full amount of such overpayment is collected. If you do have other income or available property, the amount your grant will be reduced each month will be greater.

Check here if you want your benefits reduced or discontinued now, as described in this Notice of Action.

☐ Cash Aid ☐ Food Stamps

If you checked the box(es) and the hearing decision is in your favor, any lost benefits will be made up.

Signature	Date
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The information you provide on this form is needed to process your request for a hearing, and processing may be delayed if your request is incomplete. A case file will be set up by the Chief Referee. You have a right to examine the materials that make up the file and may

NA Back 5 (Cash Aid/FS)

do so by contacting Public Inquiry and Response. Any information you provide may be shared with the county welfare department, with the U.S. Department of Health and Human Services, or the U.S. Department of Agriculture. Authority W&IC 10950.